INFANT TO PRESCHOOL CHILD PATIENT INTRODUCTION
6 MONTHS to 5 YEARS

Full Name: ____ Date: ________________
FIRST MIDDLE LAST YYYY / MM / DD

Mailing Address ____
STREET CITY PROVINCE POSTAL CODE

Birth date: ________________ Age: _______ Height: _______ Weight: _______ ❑ Male ❑ Female
YYYY / MM / DD LBS.

Alberta Health Care #: ______________________________ ❑ My Child does not have AHC Coverage

Mother and/or Father's Name: __________________________ Home Phone #: ________________

Mother and/or Father's Occupation: _______________________ Work Phone #: ________________

Number and Ages of Siblings: Brothers: # ______ Ages: __________ Sisters: # ______ Ages: __________

We were referred by: ❑ FRIEND / RELATIVE ❑ DOCTOR ❑ PHONE BOOK ❑ SIGN

If you were referred by a doctor, friend or relative, please give their name: __________________________

Present MD? ____________________ Date of last MD Visit and reason: ________________________

Has your child previously seen a chiropractor? ❑ SINCE JULY 1 ❑ OVER A YEAR AGO θ NEVER

Who did your child see? ____

Describe your child's main health concern: ____

How long has your child had this condition? ____

❑ YES ❑ NO Has your child had these or similar conditions in the past? When? ________________

What activities aggravate your child's condition? ________________________________

Is this condition getting worse? ❑ YES ❑ NO ❑ Or is it CONSTANT

❑ YES ❑ NO Is this condition interfering with any of your child's daily activities? Check all that apply:

❑ PLAY ❑ SLEEP ❑ DAILY ROUTINES ❑ OTHER ______________________

❑ YES ❑ NO Any Hospitalizations? Explain: ____

❑ YES ❑ NO Vitamins/ Nutritional supplements? Type: ______________________________

❑ YES ❑ NO Is your child currently taking any Medications?

Please list by name: ____

Please list any surgeries your child has had and the date(s): ____________________________________

Has your child ever been in an auto accident? ❑ NEVER ❑ PAST YEAR ❑ LAST 5 YEARS ❑ OVER 5 YEARS

Describe:

____

____

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HISTORY OF BIRTH:
During the pregnancy did the mother:

❑ YES ❑ NO Have any traumas (falls, accidents, etc.)? Explain: ______________________________

❑ YES ❑ NO Take any drugs or vitamins? Please List: ______________________________

❑ YES ❑ NO Have any illnesses? Please List: ______________________________

❑ YES ❑ NO Have any invasive procedures (amniocentesis, CVs)? ______________________________

❑ YES ❑ NO Have any exposures to Ultrasound? How many? ________ Medical Reason? ____________

❑ YES ❑ NO Smoke? How often? ______________ Alcohol?: ______________________________

Was the baby born: ❑ In a HOSPITAL: ______________ ❑ At HOME ❑ By a MIDWIFE:______________

❑ YES ❑ NO Was Labor Induced? Duration of gestation: ______________________________

❑ YES ❑ NO Was it a Vaginal Birth: If *NO*: ❑ FORCEPS ❑ VACUUM EXTRACTION ❑ C-SECTION

Birth weight: ______________________ Birth Length: ___________________________

❑ YES ❑ NO Were medications delivered to mother at birth: If *YES*, Please list: ____________________

Duration of Birth: ______________________________

AFTER DELIVERY:

❑ YES ❑ NO Was there any difficulty with mother's lactation? Explain: ___________________________

❑ YES ❑ NO Was there any evidence of birth trauma? Which? ❑ Bruising ❑ Odd shaped head

❑ Respiratory Depression ❑ Cord around Neck ❑ Other: ______________________

❑ YES ❑ NO Was this baby breast fed? How Long? ________ Formula introduced at what age? ________

Type of formula used? ______________ Introduction of cow's milk at what age? ________

Began solid Foods at what age? ________ Type? ______________________________

❑ YES ❑ NO Food/Juice Intolerance? Type: ______________________________

❑ YES ❑ NO Any smokers in the home? How much? ______________________________

❑ YES ❑ NO Any pets at home? Type: ______________________________

❑ YES ❑ NO Any vaccinations? Which ones and any reactions? ______________________________

❑ YES ❑ NO Any behavioral problems? Explain: ______________________________

❑ YES ❑ NO Do sleeping patterns seem normal to you? Explain: ______________________________

❑ YES ❑ NO Any falls from couches, beds, change tables, etc? ______________________________

Average number of hours child watches TV per week: ______________________________

At what age did the child: Crawl? ___________________________ Walk? ___________________________

❑ YES ❑ NO Any <u>MAJOR</u> health problems in the immediate family (Cancer, Disease, Diabetes, Etc.)?

Please List:

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NUTRITION

YES	NO	
❑	❑	Does your child have any digestive disturbances? ___
❑	❑	Does your child have any sugar cravings? ___
❑	❑	Does your child have any food allergies? ___
❑	❑	Does your child have any persistent or intermittent skin rashes? ___

INJURIES

YES	NO	
❑	❑	Has your child had any RECENT falls or injuries? ___
		Describe the injury and the date it occurred: ___
❑	❑	Has your child ever had a bone fracture or joint dislocation? ___
❑	❑	Has your child had any other injuries? ___
❑	❑	Does your child often trip and fall? Describe: ___

Do you have any other concerns about your child's growth and development? Describe:

___

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HEALTH HISTORY

YES	NO	
❑	❑	Has your child had colic? ___
❑	❑	Has your child had any stomach / intestinal discomfort? ___
❑	❑	Has your child had any upper respiratory infections or asthma? How often? ___
❑	❑	Does your child ever complain of neck or back pain? ___
❑	❑	Does your child ever complain of pains in the arms or legs? ___
❑	❑	Does your child ever complain of headaches? ___
❑	❑	Has your child had any earaches? At what age was the first earache? ___
		How frequently does your child have earaches? ___
		Is the pain in the right and/or left ear? ___
❑	❑	Has your child had any other illnesses? ___
❑	❑	Do you have any other concerns about your child's health? ___

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